KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S**
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 10/27/2017 Time: 10:03 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL (14-1338) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2016 and ending 06/30/2017, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		607,017	184,366			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		40,570				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			223,716			10
10.01	HEALTH CLINIC - RHC II						10.01
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		647,587	408,082			200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 1900 STATE STREET	P.O. Box:			1
2	City: CHESTER	State: IL	ZIP Code: 62233	County: RANDOLPH	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	MEMORIAL HOSPITAL	14-1338	99914	1	09 / 01 / 2004	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	MEMORIAL HOSPITAL-SWING BEDS	14-Z338	99914		09 / 01 / 2004	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	CHESTER CLINIC	14-8543	99914		06 / 01 / 2015	N	O	N	15
15.01	Hospital-Based Health Clinic - RHC II	CHESTER CLINIC	14-8542	99914		06 / 01 / 2015	N	O	N	15.01
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2016	To: 06 / 30 / 2017	20
21	Type of control (see instructions)	8		21

	Inpatient PPS Information	1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS				
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers				
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	Y	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers		1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?	Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Y	Y	Y	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	286,632	5,745		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.		N	125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	Contractor's Name:	Contractor's Number:		141
142	Street:	P.O. Box:			142
143	City:	State:	ZIP Code:		143
144	Are provider based physicians' costs included in Worksheet A?			Y	144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.			N	N 145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.			N	146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.			N	147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.			N	148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.			N	149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			07 / 01 / 2016	06 / 30 / 2017 170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)			N	0 171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	12/31/2017	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/19/2017	Y	09/19/2017	17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	N	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	N	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	N	27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	Y	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?	N		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

Cost Report Preparer Contact Information				
41	First name: RAJ	Last name: SHAH	Title: MANAGER	41
42	Employer: STRATEGIC REIMBURSEMENT GROUP, LLC			42
43	Phone number: 630-530-7100 X 107	E-mail Address: RAJ.SHAH@SRGROUPLLC.COM		43

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips			
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients
		1	2	3	4	5	6	7	8
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	37,724.00		859	129	1,551
2	HMO and other (see instructions)						240		
3	HMO IPF Subprovider								
4	HMO IRF Subprovider								
5	Hospital Adults & Peds. Swing Bed SNF						60		60
6	Hospital Adults & Peds. Swing Bed NF								88
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	37,724.00		919	129	1,699
8	Intensive Care Unit	31							
9	Coronary Care Unit	32							
10	Burn Intensive Care Unit	33							
11	Surgical Intensive Care Unit	34							
12	Other Special Care (specify)	35							
13	Nursery	43							
14	Total (see instructions)		25	9,125	37,724.00		919	129	1,699
15	CAH Visits								
16	Subprovider - IPF	40							
17	Subprovider - IRF	41							
18	Subprovider I	42							
19	Skilled Nursing Facility	44							
20	Nursing Facility	45							
21	Other Long Term Care	46							
22	Home Health Agency	101							
23	ASC (Distinct Part)	115							
24	Hospice (Distinct Part)	116							
24.10	Hospice (non-distinct part)	30							
25	CMHC	99							
26	RHC	88					7,358		24,932
26.01	RHC II	88.01							
27	Total (sum of lines 14-26)		25						
28	Observation Bed Days								358
29	Ambulance Trips								
30	Employee discount days (see instructions)								
31	Employee discount days-IRF								
32	Labor & delivery (see instructions)								
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								
33	LTCH non-covered days								

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					233	38	460	1
2	HMO and other (see instructions)					70			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		210.08			233	38	460	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		49.78						26
26.01	RHC II								26.01
27	Total (sum of lines 14-26)		259.86						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	/ /	2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1				54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)				207

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-8543** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 2319 OLD PLANK	1
2	City: CHESTER State: IL ZIP Code: 62223 County: RANDOLPH	2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	Other (specify)			9

		1	2	
10	Does this facility operate as other than a hospital-based RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N		10

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	Y	2	13
14	RHC/FQHC name: MEMORIAL HOSPITAL, RHC CCN number: 14-8542			14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.517848	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	1,571,412	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	6,236,257	6
7	Medicaid cost (line 1 times line 6)	3,229,433	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	1,658,021	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,658,021	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)		305,340	305,340	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)		305,340	305,340	21
22	Payments received from patients for amounts previously written off as charity care		152,627	152,627	22
23	Cost of charity care (line 21 minus line 22)		152,713	152,713	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	1,732,813	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	172,710	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	265,709	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)	1,467,104	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	852,736	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,005,449	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,663,470	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		955,680	955,680	-441,475	514,205		514,205	1
2	00200	Cap Rel Costs-Mvble Equip				632,982	632,982	-27,173	605,809	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	177,777	3,467,023	3,644,800		3,644,800		3,644,800	4
5	00500	Administrative & General	1,438,619	1,290,016	2,728,635	582,778	3,311,413	-85,884	3,225,529	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	349,570	484,510	834,080	-149	833,931		833,931	7
8	00800	Laundry & Linen Service	46,667	58,190	104,857		104,857		104,857	8
9	00900	Housekeeping	310,431	52,225	362,656		362,656		362,656	9
10	01000	Dietary	352,948	194,787	547,735	-348,313	199,422		199,422	10
11	01100	Cafeteria				348,313	348,313	-60,723	287,590	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	418,690	5,109	423,799		423,799		423,799	13
14	01400	Central Services & Supply	61,117	513,846	574,963	-509,096	65,867		65,867	14
15	01500	Pharmacy	333,436	448,213	781,649	-359,367	422,282	-65,375	356,907	15
16	01600	Medical Records & Library	380,290	80,092	460,382		460,382	-2,819	457,563	16
17	01700	Social Service		5,934	5,934		5,934		5,934	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,828,467	66,613	1,895,080		1,895,080		1,895,080	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	633,397	186,418	819,815	-66,000	753,815		753,815	50
54	05400	Radiology-Diagnostic	825,039	548,703	1,373,742		1,373,742	-200	1,373,542	54
60	06000	Laboratory	651,320	773,979	1,425,299	-14,362	1,410,937		1,410,937	60
62	06200	Whole Blood & Packed Red Blood Cells	31,183	65,121	96,304		96,304		96,304	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	Intravenous Therapy		77,626	77,626	-69,222	8,404		8,404	64
65	06500	Respiratory Therapy	237,345	60,555	297,900	-330	297,570	-35,564	262,006	65
66	06600	Physical Therapy		402,828	402,828		402,828		402,828	66
67	06700	Occupational Therapy		68,243	68,243		68,243		68,243	67
68	06800	Speech Pathology		38,841	38,841		38,841		38,841	68
71	07100	Medical Supplies Charged to Patients				403,014	403,014		403,014	71
72	07200	Impl. Dev. Charged to Patients				175,304	175,304		175,304	72
73	07300	Drugs Charged to Patients				315,627	315,627		315,627	73
76	03950	CARDIAC REHAB		23,917	23,917	-23,917				76
76.01	03951	CHEMOTHERAPY	165,760	1,340,410	1,506,170		1,506,170	-143,650	1,362,520	76.01
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	2,817,125	2,106,735	4,923,860	-649,704	4,274,156	-964,030	3,310,126	88
90	09000	Clinic	180,609	95,887	276,496		276,496	-72,947	203,549	90
91	09100	Emergency	366,038	1,537,074	1,903,112		1,903,112	-1,035,829	867,283	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	11,605,828	14,948,575	26,554,403	-23,917	26,530,486	-2,494,194	24,036,292	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	3,477		3,477		3,477		3,477	190
192	19200	Physicians' Private Offices								192
193.01	19301	CARDIAC REHAB				23,917	23,917		23,917	193.01
194	07950	NON-ALLOWABLE COSTS								194
200		TOTAL (sum of lines 118-199)	11,609,305	14,948,575	26,557,880		26,557,880	-2,494,194	24,063,686	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS DRUG COST	A	Drugs Charged to Patients	73		315,627	1
500	Total reclassifications					315,627	500
	Code Letter - A						
1	RECLASS DEPRECIATION	B	Cap Rel Costs-Mvble Equip	2		508,341	1
500	Total reclassifications					508,341	500
	Code Letter - B						
1	RECLASS MEDICAL SUPPLIES	C	Medical Supplies Charged to P	71		333,792	1
2	RECLASS MEDICAL SUPPLIES	C	Impl. Dev. Charged to Patient	72		175,304	2
500	Total reclassifications					509,096	500
	Code Letter - C						
1	I V THERAPY MED SUPPLIES	D	Medical Supplies Charged to P	71		69,222	1
500	Total reclassifications					69,222	500
	Code Letter - D						
1	CARDIAC REHAB	E	CARDIAC REHAB	193.01		23,917	1
500	Total reclassifications					23,917	500
	Code Letter - E						
1	CAFETRIA	F	Cafeteria	11	224,445	123,868	1
500	Total reclassifications				224,445	123,868	500
	Code Letter - F						
1	RHC MALPRACTICE	G	Administrative & General	5		65,895	1
500	Total reclassifications					65,895	500
	Code Letter - G						
1	LEASE/RENTAL	H	Cap Rel Costs-Mvble Equip	2		124,641	1
2							2
3							3
4							4
5							5
6							6
500	Total reclassifications					124,641	500
	Code Letter - H						
1	RHC ADMINISTRATION	I	Administrative & General	5	383,063	200,746	1
500	Total reclassifications				383,063	200,746	500
	Code Letter - I						
1	RECLASS PROPERTY INSURANCE	L	Cap Rel Costs-Bldg & Fixt	1		66,866	1
500	Total reclassifications					66,866	500
	Code Letter - L						
	GRAND TOTAL (Increases)				607,508	2,008,219	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	RECLASS DRUG COST	A	Pharmacy	15		315,627		1
500	Total reclassifications					315,627		500
	Code letter - A							
1	RECLASS DEPRECIATION	B	Cap Rel Costs-Bldg & Fixt	1		508,341	9	1
500	Total reclassifications					508,341		500
	Code letter - B							
1	RECLASS MEDICAL SUPPLIES	C	Central Services & Supply	14		509,096		1
2	RECLASS MEDICAL SUPPLIES	C						2
500	Total reclassifications					509,096		500
	Code letter - C							
1	I V THERAPY MED SUPPLIES	D	Intravenous Therapy	64		69,222		1
500	Total reclassifications					69,222		500
	Code letter - D							
1	CARDIAC REHAB	E	CARDIAC REHAB	76		23,917		1
500	Total reclassifications					23,917		500
	Code letter - E							
1	CAFETRIA	F	Dietary	10	224,445	123,868		1
500	Total reclassifications				224,445	123,868		500
	Code letter - F							
1	RHC MALPRACTICE	G	Rural Health Clinic	88		65,895		1
500	Total reclassifications					65,895		500
	Code letter - G							
1	LEASE/RENTAL	H	Administrative & General	5		60	10	1
2			Operation of Plant	7		149	10	2
3			Pharmacy	15		43,740	10	3
4			Operating Room	50		66,000	10	4
5			Laboratory	60		14,362	10	5
6			Respiratory Therapy	65		330	10	6
500	Total reclassifications					124,641		500
	Code letter - H							
1	RHC ADMINISTRATION	I	Rural Health Clinic	88	383,063	200,746		1
500	Total reclassifications				383,063	200,746		500
	Code letter - I							
1	RECLASS PROPERTY INSURANCE	L	Administrative & General	5		66,866	12	1
500	Total reclassifications					66,866		500
	Code letter - L							
	GRAND TOTAL (Decreases)				607,508	2,008,219		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	237,440					237,440		1
2	Land Improvements	571,456					571,456		2
3	Buildings and Fixtures	15,234,651	406,737		406,737		15,641,388		3
4	Building Improvements								4
5	Fixed Equipment	928,850					928,850		5
6	Movable Equipment	10,064,544	692,695		692,695		10,757,239		6
7	HIT-designated Assets	1,687,027					1,687,027		7
8	Subtotal (sum of lines 1-7)	28,723,968	1,099,432		1,099,432		29,823,400		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	28,723,968	1,099,432		1,099,432		29,823,400		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	955,680						955,680	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	955,680						955,680	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	16,570,238		16,570,238	0.571102					1
2	Cap Rel Costs-Mvble Equ	12,444,266		12,444,266	0.428898					2
3	Total (sum of lines 1-2)	29,014,504		29,014,504	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	447,339			66,866			514,205	1
2	Cap Rel Costs-Mvble Equip	481,168	124,641					605,809	2
3	Total (sum of lines 1-2)	928,507	124,641		66,866			1,120,014	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)	B	-1,391	Administrative & General	5		4
5	Refunds and rebates of expenses (chapter 8)	B	-65,375	Pharmacy	15		5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-6,707	Administrative & General	5		7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,287,990				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-60,723	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-2,819	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-27,173	Cap Rel Costs-Mvble Equip	2	9	32
33	IHA NON ALLLOW EXCESS DISALLOW-ADD	A	2,087	Administrative & General	5		33
34							34
35							35
36	TRASNCRIPTION AND OTHER MISC	B	-10,678	Rural Health Clinic	88		36
36.03	ADMINISTRATIVE & GENERAL - MISC	B	-1,176	Administrative & General	5		36.03
37							37
38	NON ALLOWABLE EXP	A	-78,697	Administrative & General	5		38
38.01	NON ALLOWABLE RHC	A	-1,031	Rural Health Clinic	88		38.01
39							39
40	CRNA AND MD BILLING EXPENSE	A	-121,234	Rural Health Clinic	88		40
41	RHC CRNA EXPENSE	A	-465,000	Rural Health Clinic	88		41
42	RHC SURGEON	A	-101,632	Rural Health Clinic	88		42
42.01	RHC CONTRACT SURGEON	A	-264,455	Rural Health Clinic	88		42.01
43							43
44							44
45							45
45.02	MISC REV PET SCANNER	B	-200	Radiology-Diagnostic	54		45.02
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-2,494,194				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify:

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2	60	Laboratory AGGREGATE	20,400		20,400					2
3	65	Respiratory Therapy AGGREGATE	35,564	35,564						3
4										4
5	76.01	CHEMOTHERAPY AGGREGATE	143,650	143,650						5
6	91	Emergency AGGREGATE	1,488,751	1,035,829	452,922					6
7										7
8	90	Clinic AGGREGATE	72,947	72,947						8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,761,312	1,287,990	473,322					200

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2	60	Laboratory AGGREGATE								2
3	65	Respiratory Therapy AGGREGATE							35,564	3
4										4
5	76.01	CHEMOTHERAPY AGGREGATE							143,650	5
6	91	Emergency AGGREGATE							1,035,829	6
7										7
8	90	Clinic AGGREGATE							72,947	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,287,990	200

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

Check applicable box: [XX] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate						7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked	1,178.05	852.50	577.79			9
10	AHSEA (see instructions)	70.63	70.63	55.90			10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	35.32	35.32	27.95			11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)	83,206	14
15	Therapists (column 2, line 9 times column 2, line 10)	60,212	15
16	Assistants (column 3, line 9 times column 3, line 10)	32,298	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	175,716	17
18	Aides (column 4, line 9 times column 4, line 10)		18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	175,716	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)	175,716	23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance			
24	Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		28
Optional Travel Allowance and Optional Travel Expense			
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense			
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
Optional Travel Allowance and Optional Travel Expense			
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [XX] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	175,716	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	175,716	63
64	Total cost of outside supplier services (from provider records)	68,243	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

Check applicable box: [ ] Occupational [XX] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate						7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked	954.32	3,126.15	4,638.47	2,512.78		9
10	AHSEA (see instructions)	74.53	74.53	55.90	37.27		10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	37.27	37.27	27.95			11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)	71,125	14
15	Therapists (column 2, line 9 times column 2, line 10)	232,992	15
16	Assistants (column 3, line 9 times column 3, line 10)	259,290	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	563,407	17
18	Aides (column 4, line 9 times column 4, line 10)	93,651	18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	657,058	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)	657,058	23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance			
24	Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		28
Optional Travel Allowance and Optional Travel Expense			
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense			
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
Optional Travel Allowance and Optional Travel Expense			
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [ ] Occupational [XX] Physical [ ] Respiratory [ ] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	657,058	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	657,058	63
64	Total cost of outside supplier services (from provider records)	394,058	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [XX] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate						7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		290.96				9
10	AHSEA (see instructions)		74.53				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	37.27	37.27				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)	21,685	15
16	Assistants (column 3, line 9 times column 3, line 10)		16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	21,685	17
18	Aides (column 4, line 9 times column 4, line 10)		18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	21,685	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	74.53	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	58,133	22
23	Total salary equivalency (see instructions)	58,133	23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance			
24	Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		28
Optional Travel Allowance and Optional Travel Expense			
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense			
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
Optional Travel Allowance and Optional Travel Expense			
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [XX] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	58,133	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	58,133	63
64	Total cost of outside supplier services (from provider records)	12,393	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	514,205	514,205					1
2	Cap Rel Costs-Mvble Equip	605,809		605,809				2
4	Employee Benefits Department	3,644,800	10,489	12,358	3,667,647			4
5	Administrative & General	3,225,529	61,262	72,176	742,574	4,101,541	4,101,541	5
6	Maintenance & Repairs							6
7	Operation of Plant	833,931	82,791	97,540	142,496	1,156,758	237,674	7
8	Laundry & Linen Service	104,857	4,171	4,914	19,023	132,965	27,320	8
9	Housekeeping	362,656	10,290	12,123	126,541	511,610	105,118	9
10	Dietary	199,422	2,521	2,971	52,382	257,296	52,866	10
11	Cafeteria	287,590	14,309	16,858	91,491	410,248	84,292	11
12	Maintenance of Personnel							12
13	Nursing Administration	423,799	5,441	6,410	170,671	606,321	124,578	13
14	Central Services & Supply	65,867	7,020	8,271	24,913	106,071	21,794	14
15	Pharmacy	356,907	4,616	5,438	135,919	502,880	103,325	15
16	Medical Records & Library	457,563	21,037	24,785	155,018	658,403	135,279	16
17	Social Service	5,934	1,591	1,875		9,400	1,931	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,895,080	57,044	67,206	745,342	2,764,672	568,046	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	753,815	50,241	59,191	258,192	1,121,439	230,418	50
54	Radiology-Diagnostic	1,373,542	29,467	34,716	336,311	1,774,036	364,504	54
60	Laboratory	1,410,937	17,591	20,725	265,498	1,714,751	352,323	60
62	Whole Blood & Packed Red Blood Cells	96,304			12,711	109,015	22,399	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	8,404				8,404	1,727	64
65	Respiratory Therapy	262,006	9,202	10,842	96,749	378,799	77,830	65
66	Physical Therapy	402,828	55,722	65,649		524,199	107,705	66
67	Occupational Therapy	68,243				68,243	14,022	67
68	Speech Pathology	38,841				38,841	7,981	68
71	Medical Supplies Charged to Patients	403,014				403,014	82,806	71
72	Impl. Dev. Charged to Patients	175,304				175,304	36,019	72
73	Drugs Charged to Patients	315,627				315,627	64,851	73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	1,362,520	13,935	16,417	67,569	1,460,441	300,071	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	3,310,126				3,310,126	680,117	88
90	Clinic	203,549	18,615	21,931	73,622	317,717	65,280	90
91	Emergency	867,283	26,472	31,187	149,208	1,074,150	220,701	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	24,036,292	503,827	593,583	3,666,230	24,012,271	4,090,977	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	3,477	5,101	6,010	1,417	16,005	3,288	190
192	Physicians' Private Offices		1,714	2,019		3,733	767	192
193.01	CARDIAC REHAB	23,917	3,563	4,197		31,677	6,509	193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,063,686	514,205	605,809	3,667,647	24,063,686	4,101,541	202

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COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,394,432						7
8	Laundry & Linen Service	16,172	176,457					8
9	Housekeeping	39,896		656,624				9
10	Dietary	9,776		4,796	324,734			10
11	Cafeteria	55,478		27,218		577,236		11
12	Maintenance of Personnel							12
13	Nursing Administration	21,093		10,349		39,516	801,857	13
14	Central Services & Supply	27,217		13,353		5,768		14
15	Pharmacy	17,895		8,780		31,469		15
16	Medical Records & Library	81,561		40,015		35,891		16
17	Social Service	6,169		3,027				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	221,163	176,457	108,508	324,734	172,569	466,704	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	194,785		95,565		59,779	167,852	50
54	Radiology-Diagnostic	114,245		56,050		77,866		54
60	Laboratory	68,202		33,461		61,471		60
62	Whole Blood & Packed Red Blood Cells					2,943		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	35,677		17,504		22,400		65
66	Physical Therapy	216,037		105,991				66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	54,026		26,506		15,644	35,564	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic	72,171		35,408		17,046		90
91	Emergency	102,632		50,353		34,546	131,737	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,354,195	176,457	636,884	324,734	576,908	801,857	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	19,778		9,703		328		190
192	Physicians' Private Offices	6,646		3,260				192
193.01	CARDIAC REHAB	13,813		6,777				193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,394,432	176,457	656,624	324,734	577,236	801,857	202

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	17	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	174,203						14
15	Pharmacy		664,349					15
16	Medical Records & Library			951,149				16
17	Social Service				20,527			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	4,251		46,497	20,527	4,874,128		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	10,190		58,348		1,938,376		50
54	Radiology-Diagnostic	966		237,725		2,625,392		54
60	Laboratory	830		219,797		2,450,835		60
62	Whole Blood & Packed Red Blood Cells			6,929		141,286		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	17,926		12,148		40,205		64
65	Respiratory Therapy	1,234		39,053		572,497		65
66	Physical Therapy	32		41,686		995,650		66
67	Occupational Therapy			6,086		88,351		67
68	Speech Pathology			2,496		49,318		68
71	Medical Supplies Charged to Patients	86,437		117,838		690,095		71
72	Impl. Dev. Charged to Patients	45,396		16,399		273,118		72
73	Drugs Charged to Patients		125,276	61,006		566,760		73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	504	472,813	34,366		2,399,935		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	3,484	66,260			4,059,987		88
90	Clinic	535		8,554		516,711		90
91	Emergency	2,418		42,221		1,658,758		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	174,203	664,349	951,149	20,527	23,941,402		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					49,102		190
192	Physicians' Private Offices					14,406		192
193.01	CARDIAC REHAB					58,776		193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	174,203	664,349	951,149	20,527	24,063,686		202

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	4,874,128						30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,938,376						50
54	Radiology-Diagnostic	2,625,392						54
60	Laboratory	2,450,835						60
62	Whole Blood & Packed Red Blood Cells	141,286						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	40,205						64
65	Respiratory Therapy	572,497						65
66	Physical Therapy	995,650						66
67	Occupational Therapy	88,351						67
68	Speech Pathology	49,318						68
71	Medical Supplies Charged to Patients	690,095						71
72	Impl. Dev. Charged to Patients	273,118						72
73	Drugs Charged to Patients	566,760						73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	2,399,935						76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	4,059,987						88
90	Clinic	516,711						90
91	Emergency	1,658,758						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	23,941,402						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	49,102						190
192	Physicians' Private Offices	14,406						192
193.01	CARDIAC REHAB	58,776						193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,063,686						202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		10,489	12,358	22,847	22,847		4
5	Administrative & General		61,262	72,176	133,438	4,625	138,063	5
6	Maintenance & Repairs							6
7	Operation of Plant		82,791	97,540	180,331	888	8,000	7
8	Laundry & Linen Service		4,171	4,914	9,085	118	920	8
9	Housekeeping		10,290	12,123	22,413	788	3,538	9
10	Dietary		2,521	2,971	5,492	326	1,779	10
11	Cafeteria		14,309	16,858	31,167	570	2,837	11
12	Maintenance of Personnel							12
13	Nursing Administration		5,441	6,410	11,851	1,063	4,193	13
14	Central Services & Supply		7,020	8,271	15,291	155	734	14
15	Pharmacy		4,616	5,438	10,054	847	3,478	15
16	Medical Records & Library		21,037	24,785	45,822	966	4,554	16
17	Social Service		1,591	1,875	3,466		65	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		57,044	67,206	124,250	4,644	19,120	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		50,241	59,191	109,432	1,608	7,756	50
54	Radiology-Diagnostic		29,467	34,716	64,183	2,095	12,269	54
60	Laboratory		17,591	20,725	38,316	1,654	11,859	60
62	Whole Blood & Packed Red Blood Cells					79	754	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy						58	64
65	Respiratory Therapy		9,202	10,842	20,044	603	2,620	65
66	Physical Therapy		55,722	65,649	121,371		3,625	66
67	Occupational Therapy						472	67
68	Speech Pathology						269	68
71	Medical Supplies Charged to Patients						2,787	71
72	Impl. Dev. Charged to Patients						1,212	72
73	Drugs Charged to Patients						2,183	73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		13,935	16,417	30,352	421	10,100	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic						22,899	88
90	Clinic		18,615	21,931	40,546	459	2,197	90
91	Emergency		26,472	31,187	57,659	929	7,429	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		503,827	593,583	1,097,410	22,838	137,707	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		5,101	6,010	11,111	9	111	190
192	Physicians' Private Offices		1,714	2,019	3,733		26	192
193.01	CARDIAC REHAB		3,563	4,197	7,760		219	193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		514,205	605,809	1,120,014	22,847	138,063	202

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B**
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	189,219						7
8	Laundry & Linen Service	2,194	12,317					8
9	Housekeeping	5,414		32,153				9
10	Dietary	1,327		235	9,159			10
11	Cafeteria	7,528		1,333		43,435		11
12	Maintenance of Personnel							12
13	Nursing Administration	2,862		507		2,974	23,450	13
14	Central Services & Supply	3,693		654		434		14
15	Pharmacy	2,428		430		2,368		15
16	Medical Records & Library	11,068		1,959		2,701		16
17	Social Service	837		148				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	30,011	12,317	5,312	9,159	12,983	13,648	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	26,432		4,680		4,498	4,909	50
54	Radiology-Diagnostic	15,503		2,745		5,859		54
60	Laboratory	9,255		1,638		4,626		60
62	Whole Blood & Packed Red Blood Cells					221		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	4,841		857		1,686		65
66	Physical Therapy	29,315		5,190				66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	7,331		1,298		1,177	1,040	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic	9,793		1,734		1,283		90
91	Emergency	13,927		2,466		2,600	3,853	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	183,759	12,317	31,186	9,159	43,410	23,450	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,684		475		25		190
192	Physicians' Private Offices	902		160				192
193.01	CARDIAC REHAB	1,874		332				193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	189,219	12,317	32,153	9,159	43,435	23,450	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	17	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	20,961						14
15	Pharmacy		19,605					15
16	Medical Records & Library			67,070				16
17	Social Service				4,516			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	511		3,279	4,516	239,750		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,226		4,115		164,656		50
54	Radiology-Diagnostic	116		16,759		119,529		54
60	Laboratory	100		15,500		82,948		60
62	Whole Blood & Packed Red Blood Cells			489		1,543		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	2,157		857		3,072		64
65	Respiratory Therapy	149		2,754		33,554		65
66	Physical Therapy	4		2,940		162,445		66
67	Occupational Therapy			429		901		67
68	Speech Pathology			176		445		68
71	Medical Supplies Charged to Patients	10,401		8,310		21,498		71
72	Impl. Dev. Charged to Patients	5,462		1,156		7,830		72
73	Drugs Charged to Patients		3,697	4,302		10,182		73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	61	13,953	2,424		68,157		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	419	1,955			25,273		88
90	Clinic	64		603		56,679		90
91	Emergency	291		2,977		92,131		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	20,961	19,605	67,070	4,516	1,090,593		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					14,415		190
192	Physicians' Private Offices					4,821		192
193.01	CARDIAC REHAB					10,185		193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	20,961	19,605	67,070	4,516	1,120,014		202

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B**
PART II

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	239,750						30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	164,656						50
54	Radiology-Diagnostic	119,529						54
60	Laboratory	82,948						60
62	Whole Blood & Packed Red Blood Cells	1,543						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	3,072						64
65	Respiratory Therapy	33,554						65
66	Physical Therapy	162,445						66
67	Occupational Therapy	901						67
68	Speech Pathology	445						68
71	Medical Supplies Charged to Patients	21,498						71
72	Impl. Dev. Charged to Patients	7,830						72
73	Drugs Charged to Patients	10,182						73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	68,157						76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	25,273						88
90	Clinic	56,679						90
91	Emergency	92,131						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,090,593						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	14,415						190
192	Physicians' Private Offices	4,821						192
193.01	CARDIAC REHAB	10,185						193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,120,014						202

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT SQ FEET	NEW CAP-REL COSTS MOV EQUIP SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	87,897						1
2	Cap Rel Costs-Mvble Equip		87,897					2
4	Employee Benefits Department	1,793	1,793	8,997,466				4
5	Administrative & General	10,472	10,472	1,821,682	-4,101,541	19,962,145		5
6	Maintenance & Repairs							6
7	Operation of Plant	14,152	14,152	349,570		1,156,758	61,480	7
8	Laundry & Linen Service	713	713	46,667		132,965	713	8
9	Housekeeping	1,759	1,759	310,431		511,610	1,759	9
10	Dietary	431	431	128,503		257,296	431	10
11	Cafeteria	2,446	2,446	224,445		410,248	2,446	11
12	Maintenance of Personnel							12
13	Nursing Administration	930	930	418,690		606,321	930	13
14	Central Services & Supply	1,200	1,200	61,117		106,071	1,200	14
15	Pharmacy	789	789	333,436		502,880	789	15
16	Medical Records & Library	3,596	3,596	380,290		658,403	3,596	16
17	Social Service	272	272			9,400	272	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,751	9,751	1,828,467		2,764,672	9,751	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,588	8,588	633,397		1,121,439	8,588	50
54	Radiology-Diagnostic	5,037	5,037	825,039		1,774,036	5,037	54
60	Laboratory	3,007	3,007	651,320		1,714,751	3,007	60
62	Whole Blood & Packed Red Blood Cells			31,183		109,015		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy					8,404		64
65	Respiratory Therapy	1,573	1,573	237,345		378,799	1,573	65
66	Physical Therapy	9,525	9,525			524,199	9,525	66
67	Occupational Therapy					68,243		67
68	Speech Pathology					38,841		68
71	Medical Supplies Charged to Patients					403,014		71
72	Impl. Dev. Charged to Patients					175,304		72
73	Drugs Charged to Patients					315,627		73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	2,382	2,382	165,760		1,460,441	2,382	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic					3,310,126		88
90	Clinic	3,182	3,182	180,609		317,717	3,182	90
91	Emergency	4,525	4,525	366,038		1,074,150	4,525	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	86,123	86,123	8,993,989	-4,101,541	19,910,730	59,706	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	872	872	3,477		16,005	872	190
192	Physicians' Private Offices	293	293			3,733	293	192
193.01	CARDIAC REHAB	609	609			31,677	609	193.01
194	NON-ALLOWABLE COSTS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	514,205	605,809	3,667,647		4,101,541	1,394,432	202
203	Unit Cost Multiplier (Wkst. B, Part I)	5.850086	6.892260	0.407631		0.205466	22.681067	203
204	Cost to be allocated (Per Wkst. B, Part II)			22,847		138,063	189,219	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.002539		0.006916	3.077733	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY AND LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA GROSS SALARIES	NURSING ADMINI-STRATION SALARIES	CENTRAL SERVICES & SUPPLY COSTED REQUIS	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	1,551						8
9	Housekeeping		59,008					9
10	Dietary		431	1,551				10
11	Cafeteria		2,446		6,116,168			11
12	Maintenance of Personnel							12
13	Nursing Administration		930		418,690	2,223,987		13
14	Central Services & Supply		1,200		61,117		672,716	14
15	Pharmacy		789		333,436			15
16	Medical Records & Library		3,596		380,290			16
17	Social Service		272					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,551	9,751	1,551	1,828,467	1,294,425	16,415	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		8,588		633,397	465,545	39,349	50
54	Radiology-Diagnostic		5,037		825,039		3,731	54
60	Laboratory		3,007		651,320		3,205	60
62	Whole Blood & Packed Red Blood Cells				31,183			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy						69,223	64
65	Respiratory Therapy		1,573		237,345		4,766	65
66	Physical Therapy		9,525				123	66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients						333,791	71
72	Impl. Dev. Charged to Patients						175,304	72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		2,382		165,760	98,638	1,948	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic						13,456	88
90	Clinic		3,182		180,609		2,066	90
91	Emergency		4,525		366,038	365,379	9,339	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,551	57,234	1,551	6,112,691	2,223,987	672,716	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		872		3,477			190
192	Physicians' Private Offices		293					192
193.01	CARDIAC REHAB		609					193.01
194	NON-ALLOWABLE COSTS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	176,457	656,624	324,734	577,236	801,857	174,203	202
203	Unit Cost Multiplier (Wkst. B, Part I)	113.769826	11.127711	209.370729	0.094379	0.360549	0.258955	203
204	Cost to be allocated (Per Wkst. B, Part II)	12,317	32,153	9,159	43,435	23,450	20,961	204
205	Unit Cost Multiplier (Wkst. B, Part II)	7.941328	0.544892	5.905222	0.007102	0.010544	0.031159	205

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS				
		15	16	17				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	1,673,798						15
16	Medical Records & Library		40,430,588					16
17	Social Service			1,551				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,976,473	1,551				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		2,480,235					50
54	Radiology-Diagnostic		10,104,430					54
60	Laboratory		9,343,105					60
62	Whole Blood & Packed Red Blood Cells		294,533					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy		516,374					64
65	Respiratory Therapy		1,660,052					65
66	Physical Therapy		1,772,001					66
67	Occupational Therapy		258,683					67
68	Speech Pathology		106,120					68
71	Medical Supplies Charged to Patients		5,009,057					71
72	Impl. Dev. Charged to Patients		697,091					72
73	Drugs Charged to Patients	315,627	2,593,250					73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	1,191,232	1,460,846					76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	166,939						88
90	Clinic		363,615					90
91	Emergency		1,794,723					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,673,798	40,430,588	1,551				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
193.01	CARDIAC REHAB							193.01
194	NON-ALLOWABLE COSTS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	664,349	951,149	20,527				202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.396911	0.023525	13.234687				203
204	Cost to be allocated (Per Wkst. B, Part II)	19,605	67,070	4,516				204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.011713	0.001659	2.911670				205

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POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	4,874,128		4,874,128			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,938,376		1,938,376			50
54	Radiology-Diagnostic	2,625,392		2,625,392			54
60	Laboratory	2,450,835		2,450,835			60
62	Whole Blood & Packed Red Blood Cells	141,286		141,286			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	40,205		40,205			64
65	Respiratory Therapy	572,497		572,497			65
66	Physical Therapy	995,650		995,650			66
67	Occupational Therapy	88,351		88,351			67
68	Speech Pathology	49,318		49,318			68
71	Medical Supplies Charged to Patients	690,095		690,095			71
72	Impl. Dev. Charged to Patients	273,118		273,118			72
73	Drugs Charged to Patients	566,760		566,760			73
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	2,399,935		2,399,935			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	4,059,987		4,059,987			88
90	Clinic	516,711		516,711			90
91	Emergency	1,658,758		1,658,758			91
92	Observation Beds (Non-Distinct Part)	883,805		883,805			92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	24,825,207		24,825,207			200
201	Less Observation Beds	883,805		883,805			201
202	Total (line 200 minus line 201)	23,941,402		23,941,402			202

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	1,545,256		1,545,256				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	315,889	2,164,346	2,480,235	0.781529			50
54	Radiology-Diagnostic	332,511	9,771,919	10,104,430	0.259826			54
60	Laboratory	754,958	8,588,147	9,343,105	0.262315			60
62	Whole Blood & Packed Red Blood Cells	105,934	188,599	294,533	0.479695			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	15,549	500,825	516,374	0.077860			64
65	Respiratory Therapy	264,430	1,395,622	1,660,052	0.344867			65
66	Physical Therapy	209,145	1,562,856	1,772,001	0.561879			66
67	Occupational Therapy	59,817	198,866	258,683	0.341542			67
68	Speech Pathology	17,863	88,257	106,120	0.464738			68
71	Medical Supplies Charged to Patients	1,116,468	3,892,589	5,009,057	0.137769			71
72	Impl. Dev. Charged to Patients	480,315	216,776	697,091	0.391797			72
73	Drugs Charged to Patients	552,694	2,040,556	2,593,250	0.218552			73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	884	1,459,962	1,460,846	1.642839			76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		5,801,934	5,801,934				88
90	Clinic		363,615	363,615	1.421039			90
91	Emergency	10,000	1,784,723	1,794,723	0.924242			91
92	Observation Beds (Non-Distinct Part)	1,432	429,785	431,217	2.049560			92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	5,783,145	40,449,377	46,232,522				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	5,783,145	40,449,377	46,232,522				202

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1338** **WORKSHEET D PART V**

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.781529		770,730			602,348		50
54	Radiology-Diagnostic	0.259826		3,224,528	180		837,816	47	54
60	Laboratory	0.262315		3,106,579	696		814,902	183	60
62	Whole Blood & Packed Red Blood	0.479695		82,284			39,471		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.077860		219,656			17,102		64
65	Respiratory Therapy	0.344867		507,397			174,984		65
66	Physical Therapy	0.561879		517,695	182		290,882	102	66
67	Occupational Therapy	0.341542		60,868			20,789		67
68	Speech Pathology	0.464738		24,752			11,503		68
71	Medical Supplies Charged to Pat	0.137769		1,252,077	375		172,497	52	71
72	Impl. Dev. Charged to Patients	0.391797		105,377			41,286		72
73	Drugs Charged to Patients	0.218552		1,253,492	1,382		273,953	302	73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1.642839		911,526			1,497,490		76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	1.421039		139,924	490		198,837	696	90
91	Emergency	0.924242		590,080			545,377		91
92	Observation Beds (Non-Distinct	2.049560		140,771			288,519		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			12,907,736	3,305		5,827,756	1,382	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			12,907,736	3,305		5,827,756	1,382	202

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z338** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P [ ] Hospital [ ] SUB (Other) [XX] Swing Bed SNF
[XX] Title XVIII, Part B [ ] IPF [ ] SNF [ ] Swing Bed NF
[ ] Title XIX - O/P [ ] IRF [ ] NF [ ] ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.781529							50
54	Radiology-Diagnostic	0.259826							54
60	Laboratory	0.262315							60
62	Whole Blood & Packed Red Blood	0.479695							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.077860							64
65	Respiratory Therapy	0.344867							65
66	Physical Therapy	0.561879							66
67	Occupational Therapy	0.341542							67
68	Speech Pathology	0.464738							68
71	Medical Supplies Charged to Pat	0.137769							71
72	Impl. Dev. Charged to Patients	0.391797							72
73	Drugs Charged to Patients	0.218552							73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1.642839							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	1.421039							90
91	Emergency	0.924242							91
92	Observation Beds (Non-Distinct	2.049560							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	239,750	7,935	231,815	1,909	121.43	129	15,664	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	239,750		231,815	1,909		129	15,664	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1338** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	164,656	2,480,235	0.066387	57,440	3,813	50
54	Radiology-Diagnostic	119,529	10,104,430	0.011829	49,778	589	54
60	Laboratory	82,948	9,343,105	0.008878	77,263	686	60
62	Whole Blood & Packed Red Blood	1,543	294,533	0.005239	5,409	28	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	3,072	516,374	0.005949	8,606	51	64
65	Respiratory Therapy	33,554	1,660,052	0.020213	12,614	255	65
66	Physical Therapy	162,445	1,772,001	0.091673	9,097	834	66
67	Occupational Therapy	901	258,683	0.003483	1,716	6	67
68	Speech Pathology	445	106,120	0.004193			68
71	Medical Supplies Charged to Pat	21,498	5,009,057	0.004292	161,269	692	71
72	Impl. Dev. Charged to Patients	7,830	697,091	0.011232	14,449	162	72
73	Drugs Charged to Patients	10,182	2,593,250	0.003926	51,791	203	73
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	68,157	1,460,846	0.046656	5		76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	25,273	5,801,934	0.004356			88
90	Clinic	56,679	363,615	0.155876			90
91	Emergency	92,131	1,794,723	0.051334			91
92	Observation Beds (Non-Distinct	43,473	431,217	0.100815	279	28	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	894,316	44,687,266		449,716	7,347	200

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	1,909		129		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	1,909		129		200

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-1338** **WORKSHEET D PART IV**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1338** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [XX] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	2,480,235			57,440				50
54	Radiology-Diagnostic	10,104,430			49,778				54
60	Laboratory	9,343,105			77,263				60
62	Whole Blood & Packed Red Blood	294,533			5,409				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	516,374			8,606				64
65	Respiratory Therapy	1,660,052			12,614				65
66	Physical Therapy	1,772,001			9,097				66
67	Occupational Therapy	258,683			1,716				67
68	Speech Pathology	106,120							68
71	Medical Supplies Charged to Pat	5,009,057			161,269				71
72	Impl. Dev. Charged to Patients	697,091			14,449				72
73	Drugs Charged to Patients	2,593,250			51,791				73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1,460,846			5				76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	5,801,934							88
90	Clinic	363,615							90
91	Emergency	1,794,723							91
92	Observation Beds (Non-Distinct	431,217			279				92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	44,687,266			449,716				200

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1338** **WORKSHEET D PART V**

Check Applicable Boxes:

[ ] Title V - O/P	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
[ ] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing Bed NF
[XX] Title XIX - O/P	[ ] IRF	[ ] NF	[ ] ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.781529							50
54	Radiology-Diagnostic	0.259826							54
60	Laboratory	0.262315							60
62	Whole Blood & Packed Red Blood	0.479695							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.077860							64
65	Respiratory Therapy	0.344867							65
66	Physical Therapy	0.561879							66
67	Occupational Therapy	0.341542							67
68	Speech Pathology	0.464738							68
71	Medical Supplies Charged to Pat	0.137769							71
72	Impl. Dev. Charged to Patients	0.391797							72
73	Drugs Charged to Patients	0.218552							73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1.642839							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	1.421039							90
91	Emergency	0.924242							91
92	Observation Beds (Non-Distinct	2.049560							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1338** **WORKSHEET D-1 PART I**

Check	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
Boxes:	**[ ] Title XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[XX] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,057	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,909	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,551	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	30	5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	30	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	44	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	44	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	859	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	30	10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	30	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	147.77	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	152.04	20
21	Total general inpatient routine service cost (see instructions)	4,874,128	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	6,502	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	6,690	25
26	Total swing-bed cost (see instructions)	161,316	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,712,812	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,712,812	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1338** **WORKSHEET D-1 PART II**

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Title XVIII, Part A** **[ ] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	2,468.73	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,120,639	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	2,120,639	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	665,853	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,786,492	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)	74,062	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	74,062	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	148,124	66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

Check Applicable Boxes: [ ] Title V - I/P [XX] Title XVIII, Part A [ ] Title XIX - I/P [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [ ] NF [ ] ICF/IID [ ] PPS [ ] TEFRA [XX] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					358	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,468.73	88
89	Observation bed cost (line 87 x line 88) (see instructions)					883,805	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	239,750	4,874,128	0.049188	883,805	43,473	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1338** **WORKSHEET D-1 PART I**

Check	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**
Applicable	**[ ] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
Boxes:	**[XX] Title XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[XX] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,057	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,909	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,551	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	30	5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	30	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	44	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	44	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	129	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	147.77	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	152.04	20
21	Total general inpatient routine service cost (see instructions)	4,874,128	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	6,502	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	6,690	25
26	Total swing-bed cost (see instructions)	161,316	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,712,812	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,712,812	37

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1338** **WORKSHEET D-1 PART II**

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Title XVIII, Part A** **[XX] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					2,468.73	38
39	Program general inpatient routine service cost (line 9 x line 38)					318,466	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					318,466	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					131,182	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					449,648	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	15,664	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,347	51
52	Total Program excludable cost (sum of lines 50 and 51)	23,011	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [ ] NF [XX] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					358	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1338** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		793,727		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.781529	134,161	104,851	50
54	Radiology-Diagnostic	0.259826	196,479	51,050	54
60	Laboratory	0.262315	433,815	113,796	60
62	Whole Blood & Packed Red Blood Cells	0.479695	53,376	25,604	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.077860	129	10	64
65	Respiratory Therapy	0.344867	162,531	56,052	65
66	Physical Therapy	0.561879	102,609	57,654	66
67	Occupational Therapy	0.341542	25,734	8,789	67
68	Speech Pathology	0.464738	9,431	4,383	68
71	Medical Supplies Charged to Patients	0.137769	548,169	75,521	71
72	Impl. Dev. Charged to Patients	0.391797	242,592	95,047	72
73	Drugs Charged to Patients	0.218552	315,984	69,059	73
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	1.642839			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	1.421039			90
91	Emergency	0.924242	2,170	2,006	91
92	Observation Beds (Non-Distinct Part)	2.049560	991	2,031	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,228,171	665,853	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,228,171		202

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z338** **WORKSHEET D-3**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[ ] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[XX] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.781529	112	88	50
54	Radiology-Diagnostic	0.259826	1,865	485	54
60	Laboratory	0.262315	9,078	2,381	60
62	Whole Blood & Packed Red Blood Cells	0.479695			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.077860			64
65	Respiratory Therapy	0.344867	3,722	1,284	65
66	Physical Therapy	0.561879	22,702	12,756	66
67	Occupational Therapy	0.341542	9,541	3,259	67
68	Speech Pathology	0.464738			68
71	Medical Supplies Charged to Patients	0.137769	11,846	1,632	71
72	Impl. Dev. Charged to Patients	0.391797			72
73	Drugs Charged to Patients	0.218552	12,840	2,806	73
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	1.642839			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	1.421039			90
91	Emergency	0.924242			91
92	Observation Beds (Non-Distinct Part)	2.049560			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		71,706	24,691	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		71,706		202

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1338** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		97,507		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.781529	57,440	44,891	50
54	Radiology-Diagnostic	0.259826	49,778	12,934	54
60	Laboratory	0.262315	77,263	20,267	60
62	Whole Blood & Packed Red Blood Cells	0.479695	5,409	2,595	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.077860	8,606	670	64
65	Respiratory Therapy	0.344867	12,614	4,350	65
66	Physical Therapy	0.561879	9,097	5,111	66
67	Occupational Therapy	0.341542	1,716	586	67
68	Speech Pathology	0.464738			68
71	Medical Supplies Charged to Patients	0.137769	161,269	22,218	71
72	Impl. Dev. Charged to Patients	0.391797	14,449	5,661	72
73	Drugs Charged to Patients	0.218552	51,791	11,319	73
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	1.642839	5	8	76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	1.421039			90
91	Emergency	0.924242			91
92	Observation Beds (Non-Distinct Part)	2.049560	279	572	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		449,716	131,182	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		449,716		202

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1338** **WORKSHEET E PART B**

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	5,829,138			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	5,829,138			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	5,887,429			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	161			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,987,424			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,899,844			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	3,899,844			30
31	Primary payer payments	3,091			31
32	Subtotal (line 30 minus line 31)	3,896,753			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	201,468			34
35	Adjusted reimbursable bad debts (see instructions)	130,954			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	173,957			36
37	Subtotal (see instructions)	4,027,707			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	4,027,707			40
40.01	Sequestration adjustment (see instructions)	80,554			40.01
41	Interim payments	3,762,787			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	184,366			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1338** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[XX] Hospital** **[ ] SUB (Other)** **[ ] IPF** **[ ] SNF** **[ ] IRF** **[ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				1,754,471		4,238,041	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				21,502		156,598	2
3	List separately each retroactive lump sum adjustment		.01	02/23/2017	93,421			3.01
	amount based on subsequent revision of the interim		.02	06/29/2017	93,878			3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51			02/23/2017	350,533	3.51
		Provider	.52			06/29/2017	281,319	3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		187,299		-631,852	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				1,963,272		3,762,787	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		607,017		184,366	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				2,570,289		3,947,153	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-Z338** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [ ] SUB (Other) [ ] IPF [ ] SNF [ ] IRF [XX] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				119,093			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	02/23/2017	6,700			3.01
	amount based on subsequent revision of the interim		.02	06/29/2017	4,689			3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		11,389			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				130,482			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		40,570			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				171,052			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	460	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	859	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	240	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,551	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	46,232,522	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	305,340	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z338** **WORKSHEET E-2**

Check Applicable Boxes:
[ ] Title V **[XX] Swing Bed - SNF**
[XX] Title XVIII **[ ] Swing Bed - NF**
[ ] Title XIX

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	149,605		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	24,938		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	60		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	174,543		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	174,543		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	174,543		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)			13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	174,543		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	174,543		19
19.01	Sequestration adjustment (see instructions)	3,491		19.01
20	Interim payments	130,482		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	40,570		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3**
PART V

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT

1	Inpatient services	2,786,492	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,786,492	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,814,357	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	2,814,357	19
20	Deductibles (exclude professional component)	223,291	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,591,066	22
23	Coinsurance	2,632	23
24	Subtotal (line 22 minus line 23)	2,588,434	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	52,785	25
26	Adjusted reimbursable bad debts (see instructions)	34,310	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	40,504	27
28	Subtotal (sum of lines 24 and 26)	2,622,744	28
29	Other adjustments (QUESTRATION)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,622,744	30
30.01	Sequestration adjustment (see instructions)	52,455	30.01
31	Interim payments	1,963,272	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	607,017	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1338** **WORKSHEET E-3 PART VII**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[XX] Hospital** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	449,648		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	449,648		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	449,648		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	97,507		8
9	Ancillary service charges	449,716		9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	547,223		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	547,223		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	449,648		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	449,648		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	449,648		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	449,648		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	449,648		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	449,648		40
41	Interim payments	449,648		41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	3,830,682				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	21,253,295				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-15,047,753				6
7	Inventory	1,084,475				7
8	Prepaid expenses					8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	11,120,699				11
	FIXED ASSETS					
12	Land	237,440				12
13	Land improvements	571,456				13
14	Accumulated depreciation	-500,557				14
15	Buildings	15,641,388				15
16	Accumulated depreciation	-8,602,988				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	928,850				19
20	Accumulated depreciation	-829,185				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	12,444,266				23
24	Accumulated depreciation	-9,763,880				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	10,126,790				30
	OTHER ASSETS					
31	Investments	23,999,506				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31-34)	23,999,506				35
36	Total assets (sum of lines 11, 30 and 35)	45,246,995				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,193,719				37
38	Salaries, wages and fees payable					38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	3,064,104				44
45	Total current liabilities (sum of lines 37 thru 44)	4,257,823				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)					50
51	Total liabilities (sum of lines 45 and 50)	4,257,823				51
	CAPITAL ACCOUNTS					
52	General fund balance	40,989,172				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	40,989,172				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	45,246,995				60

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		40,582,705			1
2	Net income (loss) (from Worksheet G-3, line 29)		1,019,609			2
3	Total (sum of line 1 and line 2)		41,602,314			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		41,602,314			11
12	Deductions (debit adjustments) (specify)					12
13	RECONCILING	613,142				13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		613,142			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		40,989,172			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	RECONCILING					13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	1,526,316		1,526,316	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	1,526,316		1,526,316	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	1,526,316		1,526,316	17
18	Ancillary services	4,790,595		4,790,595	18
19	Outpatient services		43,114,005	43,114,005	19
20	Rural Health Clinic (RHC)				20
20.01	RHC II				20.01
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	6,316,911	43,114,005	49,430,916	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		26,557,880	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		26,557,880	43

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	49,430,916	1
2	Less contractual allowances and discounts on patients' accounts	24,019,360	2
3	Net patient revenues (line 1 minus line 2)	25,411,556	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	26,557,880	4
5	Net income from service to patients (line 3 minus line 4)	-1,146,324	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	79,803	6
7	Income from investments	420,380	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	60,723	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	2,819	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (specify)		24
24.01	Other (340B NET REVENUE)	1,284,020	24.01
24.02	Other (REBATE)	64,988	24.02
24.03	Other (HPSA AND OTHER INCENTIVE PYMT)	73,565	24.03
24.04	Other (INTEREST)	194,815	24.04
24.05	Other (OTHER NON OP REV)	217,449	24.05
25	Total other income (sum of lines 6-24)	2,398,562	25
26	Total (line 5 plus line 25)	1,252,238	26
27	Other expenses (LOSS ON SECURITIES)	232,629	27
28	Total other expenses (sum of line 27 and subscripts)	232,629	28
29	Net income (or loss) for the period (line 26 minus line 28)	1,019,609	29

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
193.01	CARDIAC REHAB							193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS **COMPONENT CCN: 14-8543** **WORKSHEET M-1**

Check applicable box: [XX] RHC I [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	1,287,936	265,763	1,553,699		1,553,699	-101,632	1,452,067	1
2	Physician Assistant	194,059	40,044	234,103		234,103		234,103	2
3	Nurse Practitioner	108,075	22,301	130,376		130,376		130,376	3
4	Visiting Nurse								4
5	Other Nurse	413,452	85,315	498,767		498,767		498,767	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian	109,985	137,210	247,195		247,195		247,195	8
9	Other Facility Health Care Staff Costs	141,665	29,233	170,898		170,898		170,898	9
10	Subtotal (sum of lines 1 through 9)	2,255,172	579,866	2,835,038		2,835,038	-101,632	2,733,406	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement		729,455	729,455		729,455	-729,455		11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)		729,455	729,455		729,455	-729,455		14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		22,187	22,187		22,187		22,187	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment		24,432	24,432		24,432		24,432	17
18	Professional Liability Insurance		65,895	65,895	-65,895				18
19	Other Health Care Costs		168,790	168,790		168,790		168,790	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		281,304	281,304	-65,895	215,409		215,409	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,255,172	1,590,625	3,845,797	-65,895	3,779,902	-831,087	2,948,815	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		113,581	113,581		113,581		113,581	29
30	Administrative Costs	561,953	402,529	964,482	-583,809	380,673	-132,943	247,730	30
31	Total Facility Overhead (sum of lines 29 and 30)	561,953	516,110	1,078,063	-583,809	494,254	-132,943	361,311	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	2,817,125	2,106,735	4,923,860	-649,704	4,274,156	-964,030	3,310,126	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-8543** **WORKSHEET M-2**

Check applicable box: [XX] RHC I [ ] FQHC

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	4.52	16,070	4,200	18,984		1
2	Physician Assistants	1.98	5,374	2,100	4,158		2
3	Nurse Practitioners	1.00	3,488	2,100	2,100		3
4	Subtotal (sum of lines 1 through 3)	7.50	24,932		25,242	25,242	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	7.50	24,932			25,242	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	2,948,815	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	2,948,815	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	361,311	14
15	Parent provider overhead allocated to facility (see instructions)	749,861	15
16	Total overhead (sum of lines 14 and 15)	1,111,172	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,111,172	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,111,172	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	4,059,987	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-8543** **WORKSHEET M-3**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	4,059,987	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	153,972	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	3,906,015	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	25,242	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	25,242	6
7	Adjusted cost per visit (line 3 divided by line 6)	154.74	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30		8
9	Rate for program covered visits (see instructions)	154.74	154.74	154.74	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	3,680	3,681		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	569,443	569,598		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		1,139,041		16
16.01	Total program charges (see instructions)(from contractor's records)		957,440		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,372		16.02
16.03	Total program preventive costs (see instructions)		7,580		16.03
16.04	Total program non-preventive costs (see instructions)		905,169		16.04
16.05	Total program cost (see instructions)		912,749		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)				18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		167,972		19
20	Net Medicare cost excluding vaccines (see instructions)		912,749		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		70,671		21
22	Total reimbursable Program cost (line 20 plus line 21)		983,420		22
23	Allowable bad debts (see instructions)		11,456		23
23.01	Adjusted reimbursable bad debts (see instructions)		7,446		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		11,456		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		990,866		26
26.01	Sequestration adjustment (see instructions)		19,817		26.01
27	Interim payments		747,333		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		223,716		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 10/27/2017 Run Time: 10:03 Version: 2017.10 (10/21/2017)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-8543** **WORKSHEET M-4**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,733,406	2,733,406	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002171	0.007579	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	5,934	20,716	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	51,524	33,658	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	57,458	54,374	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	2,948,815	2,948,815	6
7	Total overhead (from Wkst. M-2, line 16)	1,111,172	1,111,172	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.019485	0.018439	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	21,651	20,489	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	79,109	74,863	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	334	1,166	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	236.85	64.20	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	168	481	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	39,791	30,880	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		153,972	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		70,671	16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **COMPONENT CCN: 14-8543** **WORKSHEET M-5**

Check applicable box: [XX] RHC I [ ] FQHC

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				1,305,400	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51	02/23/2017	409,188	3.51
		Provider	.52	06/29/2017	148,879	3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-558,067	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				747,333	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due)		.01		223,716	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				971,049	
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.